MENTAL HEALTH SERVICES
OVERSIGHT AND ACCOUNTABILITY COMMISSION

1600 – 9th Street
Sacramento, CA 95814
(916) 654-5585

Evaluation of Sonoma County MHSA Three Year Expenditure Plan

CSS Committee members: Rose King, Delphine Brody, Mark LaBeau, Nicette Short
April 21, 2006

Introduction:

The following identifies issues for potential oversight by the Commission, specific questions or recommendations to be addressed by Sonoma County or the Department of Mental Health, and comments intended to inform the continued work of the Commission, Sonoma County, and DMH.

Planning Process/Consumer and Family Involvement:

Sonoma County had eight "Launch" meetings attended by 209 people in five cities, and organized by a Planning Support Team. At the Launch meetings, 25 percent identified themselves as consumers, 19 percent attending identified themselves as family members of adult consumers, and four percent were family members of children who are mental health consumers. Four Content Committees were then formed, 200 people and 100 organizations participated in the 16 meetings conducted by these groups. Ten Stakeholder Workgroups were then convened and these continued to be open membership; providers and community leaders were encouraged to join. Ten workgroups had 21 meetings. A 23-member Stakeholder Leadership Group was then formed, comprised of one person from each of the ten workgroups, and the rest from county agencies. This leadership group was comprised of people recognized as very knowledgeable about the county's communities, the populations in need of mental health services, and the range of social services available through many CBO's and county sites. These people then forwarded recommendations to the 10-member Steering Committee, which included two consumers and one family member. The Steering Committee operated according to guiding principles formed by an undetermined source. The principles used to recommend service strategies included intent to adopt evidence-based practices, increase level of participation of clients and families in all aspects of mental health system, and address the needs of those with highest clinical risk and highest financial risk to the community.

Given the multi-tiered structure of the planning process, the numbers actually participating in this process seem to be very small. The CSS Committee notes that the overall participation rate is also low compared to other counties of similar size. Only 115 consumer surveys were completed. 50 percent of participants responded to a notice by Postcard, presumably from an established mailing list.

The county states that it will take steps to ensure that community participation continues throughout the implementation process. There does not appear to be any structure maintained to achieve this objective.

Many community issues were identified for each age group and for ethnic minority populations; ten community issues were identified for Transition Age Youth for instance. In each case, the table provided by the county briefly identified a Service Strategy for each Issue. However, the county form did not identify (by asterisk) which issues would be the focus of its priorities for MHSA support.
Priorities were determined by community stakeholders, according to the plan. They were guided by the four MHSA criteria and local criteria of cost effectiveness and geographic accessibility. Stakeholders representing ethnic populations identified a priority to provide more mental health services through existing community based agencies located in and connected to ethnic communities, and increased outreach utilizing peers.

Children 8-12 were identified as disproportionately unserved; 81 percent of stakeholders ranked TAY as most important service priority for MHSA funds. Consistently identified TAY aged 16-25 as priority. All agreed that TAY are not able to receive any mental health services from existing adult or children's service systems when experiencing their first psychotic break.
For adults, prevalence rate of jailed population is double that of population in the community. Budget cuts over the last several years resulted in cutting services outside of population center of Santa Rosa; many adults cannot travel to the service sites. Outreach to ethnic community stakeholder groups identified four site specific services to be provided through Community Intervention Model. A county report demonstrates knowledge of particular obstacles unique to each culture.

The end product of community outreach is comprehensive in identifying issues and compiling baseline data. ***However, the CSS Committee is concerned that the county did not achieve significant participation of consumers and family members of all ages and ethnicities, languages, and cultures, specifically among those populations that are unserved and/or underserved, and that are not likely to be reached in traditional settings****. There is very little detail, such as minutes of meetings or identification of attendees at education and outreach activities, provided on the Sonoma County MHSA website; the website does include workgroup summaries. But, more disclosure would be beneficial. For instance, the county conducted a survey, but the questions and results are not posted for public access. There is little evidence of community-wide response.*

Sonoma County representatives explained some of the methods of promoting outreach activities, including distribution of flyers at Asian and Hispanic markets. In addition, they placed newspaper ads reaching diverse communities. As an example of community outreach, the county stated that the Indian Health Project hosted some of the workgroup meetings. The plan lacks much of the detail that county staff provided at the DMH Team Review meeting in Sacramento. Many promotional activities were not referenced in the Sonoma County plan.

However, the CSS Committee remains concerned that no community meetings were held on evenings or weekends. It does not appear that sufficient accommodations were made to recruit participation of family members with children, individuals without

transportation, working people, or youth. Sonoma County asserts that its key working groups were always open to more participants. However, the county stated that it accommodated requests of participants to meet only during weekday, day-time hours, thus excluding many people and undermining the assertion that meetings are open to everyone. It could appear likely that only traditional stakeholders attended most meetings. ***The CSS Committee strongly recommends that Sonoma County take steps to encourage wider participation. Evidence of broad participation is seriously lacking.***
Will Sonoma County initiate meetings during the implementation process at times and places more suitable to accommodate consumers, family members, and nontraditional participants?
Sonoma County states that it will "take steps" toward continued community involvement, but those steps remain to be developed.

Fully Served, Underserved/Inappropriately Served

Sonoma County estimates that a large percentage of children and youth (0-18) are fully served, while less than 10 percent of TAY and adults are fully served, according to their estimates. The county did not break out population of Transition Age Youth to report on quality of services available to them. *The Committee notes that county data identified older adults as the largest unserved population, but did not make older adult programs a priority for funding.*

The county lists many objectives to reach the unserved and underserved populations in need of culturally competent services that are not available today. *The CSS Committee noted, however, that Sonoma County provided video demonstrations of best practices on several topics, but did not address cultural competency in this educational agenda. In addition, the Committee is concerned that the Mental Health courts program does not reference ethnic minorities, while minorities are disproportionately represented in both juvenile and adult populations incarcerated and in need of mental health services.*

Sonoma County did not address the question of establishing a Children's Wraparound program as an essential component of MHSA implementation. ***The County states that an existing program is appropriate to develop for meeting Wraparound criteria, and they plan to use this program as a foundation for meeting requirements within three years****.*

The Mental Health Services Act includes a very specific requirement that all counties must develop a Wraparound Program for children and their families as an alternative to group home placement. This is a requirement of specific interest to the Oversight and Accountability Commission as it is an essential component of transforming children's mental health services by reducing unnecessary reliance on institutional care and developing intensive community services and supports for seriously emotionally disturbed/mentally ill children, adolescents and their families. Specifically, the MHSA (Section 10, Part 3.7, section 5847(a) (2) states:

> "Each county mental health program shall prepare and submit a three year plan which shall be updated at least annually and approved by the department after review and comment by the Oversight and Accountability Commission. The plan and update shall include all of the following … (2) A program for services to children in accordance with Part 4 to include a program pursuant to Chapter 6 of Part 4 of

Division 9 commencing with Section 18250, or provide substantial evidence that it is not feasible to establish a wraparound program in that county."

According to Webster's New Collegiate Dictionary, "feasible" means "capable of being done or carried out."

Wraparound, as defined in W&I Code commencing with Section 18250(a), is intended "to provide children with service alternatives to group home care through the development of expanded family-based services programs." Note that this statutory language states that wraparound service is an alternative to group home care – not simply a step-down program. SB 163 programs, codified in Section 18250-18257 of the W&I Code, are very intensive services for children or adolescents who would otherwise be placed in high-level group homes at Rate Classification Level (RCL) Level 10 through 14. SB 163 makes the funds that otherwise would have been used for group home placement available instead for intensive Wraparound service as an alternative to the group home placement. This level of funding is essential to assure that the level of staffing and intensity of service required to support children with this high level of need is provided, so that SB 163 Wraparound Programs are in fact a viable alternative to intensive group home programs. The California Department of Social Services (CDSS) document "Review of Wraparound Standards, Guidelines for Planning and Implementation" (attached) includes the staffing ratios expected in a SB 163 Wraparound program.

It should be noted that SB 163 was based on the premise that the state and county share of the nonfederal reimbursement for group home placement would instead be made available to support Wraparound as an alternative to group home placement in a manner that was cost neutral to the state and to the county, i.e., it would cost the state and the county no more to provide intensive Wraparound services than they otherwise would have spent for group home placement for the same child. Because almost all the children that are, or otherwise would be placed in a group home program, are eligible for MediCal and EPSDT, very few MHSA funds other than the 5% EPSDT match are required to develop a SB 163 Wraparound program. The W&I Code commencing with section 18250, which is the code section for SB 163 programs, states, in part, "(b) It is the further intent of the legislature that the pilot project include the following elements: (1) making available to the county the state share of nonfederal reimbursement for group home placement, minus the state share, if any, of any concurrent out-of-home placement costs, for children eligible under this chapter, for the purpose of allowing the county to develop family-based service alternatives." Section 18254 (c) states "The department shall reimburse each county, for the purpose of providing intensive wraparound services, up to 100 percent of the state share of nonfederal funds, to be matched by each county's share of cost as established by law, and to the extent permitted by federal law, up to 100 percent of the federal funds allocated for group home placements of eligible children, at the rate authorized pursuant to subdivision (a)." Accordingly, any new or expanded Wraparound program meeting the requirements of the MHSA should include the state and county share of the group home rate for each wraparound slot to assure that the level of staffing and intensity of service required to support children with this high level of need is provided.

The Mental Health Services Act, anticipating that counties would need technical assistance to develop SB 163 Wraparound programs, includes a provision (Section 6, 18257(b) that funds from the Mental Health Services Fund shall be made available to the Department of Social Services for technical assistance to counties in establishing and administering these projects. This technical assistance is available, at no cost to the county, by contacting Cheryl Treadwell, Program Manager, CDSS, at (916) 651-6023.

Sonoma County will provide detail and clarify how and when SB 163 Wraparound Program will be established.

Wellness/Recovery/Resilience:

The CSS Committee supports observations of DMH Team Review, noting that the Sonoma County plan did not sufficiently address methods and strategies for developing recovery model programs. The plan was very sketchy in referencing elements of wellness, recovery, resiliency. *The CSS Committee asks--Where are the elements of consumer and family driven programs? Where are the transformational elements in Sonoma County's plans? How will Sonoma County change the culture and environment for delivering mental health services?*

Full Service Partnerships as well as system development programs did not focus on these elements of the MHSA. ***The CSS Committee will be concerned to see that the county provides greater detail as to how these concepts will be incorporated into program strategies, training, and retraining of staff.***

Collaboration:

The Sonoma County plan enlisted participation of many community organizations, familiar with collaborative projects. At the DMH Review Team meeting, the county provided additional information regarding collaboration, and clarified how they engaged diverse groups in planning. Much of this detail is not provided in the narrative. For instance, it does not appear that mental health services will be provided at community agencies serving ethnic minorities. Such services are referenced, but plans to contract with agencies such as the Indian Health Project are not spelled out. Sonoma County representatives state that plans call for serving ethnic communities in a culturally competent manner, and that the programs and contracts were developed in cooperation with appropriate existing agencies.

The CSS Committee will be interested in learning of the county's experience and report of successes in collaborative efforts such as these.

Workplans:

As noted by DMH, county programs lacked budget detail. *CSS Committee members identified conflicting budget numbers in some instances,* and the *CSS Committee will be interested in reviewing in the future. **Budget narratives provided do not reveal significant information, and the lists of services to be provided are not clear.***

Two Intensive Services Programs serve Children and Youth. The county says it will leverage other funding to increase service levels. The CSS Committee expressed concerns that these programs could appear to be supplanting funds cut from existing programs, but Sonoma County explained the program development as providing enhanced services to children and youth who have not responded to traditional levels of service. The county explained relationships between MHSA programs and special education student services. *The County needs to further develop these narratives to provide sufficient information regarding available services, and specific components of programs.*

Forensic Assertive Community Team is linked to the county's mental health court. While the objectives of this program may be to better serve mental health consumers to avoid repeated incarcerations and provide a necessary level of services, this program does not appear to be transformational. There are questionable components to the program, including attendance requirements.

The CSS Committee is concerned that this is not an evidence-based program, and is very weak on client-driven elements. The Peer Advocate and Peer Mentoring positions are not described in a manner that leads to serious utilization of peers. ***The Committee is not satisfied that this program meets the objectives of the MHSA. Further, the CSS Committee objects to funding of a Probation Officer, and recommends against MHSA expenditures for this purpose.*** *Many county governments are experiencing fiscal problems and budget cuts in a wide range of programs.* ***MHSA funds should not be viewed as a source of revenue for any purpose other than mental health services, as specified by the Act, and are not a source of revenue for personnel in other departments that may have routine interactions with mental health consumers for a variety of reasons****. Collaborative partners are expected to contribute to the success of programs.*

Supportive Housing program will provide housing with full services for young adults, adults, and older adults and aims to reach ethnically diverse populations. Sonoma County clarified the plan narrative to explain that women consumers may occupy these residences for up to 18 months (not the 60 days referenced in the plan). This housing is to be developed as affordable, transitional residences, with intensive community services. Some of the housing is to be permanent, affordable housing, but this is not explained. *The CSS Committee notes that Sonoma County needs to provide much more detail about this program, and explain how the county aims to achieve the ambitious objectives intended to reach consumers of diverse cultures, ages, and genders. What are the supports to be provided? What is available for consumers with children?*

A Community Intervention Team also aims to reach diverse communities, targeting underserved and unserved ethnic minority communities. The plan narrative fails to explain important elements, such as strategies to effectively deliver these services. Sonoma County explained plans to contract with agencies serving Asian, Latino, Native American, and African American communities, but these plans are not adequately described in the narrative. The county addressed questions raised by the CSS Committee, particularly providing information about outreach and service sites. *The CSS Committee will want to understand how these community collaboratives are developed and*

implemented. Programs have great potential and could be very successful in reaching consumers who would otherwise remain unserved. ***The Committee is concerned about the very low budget projected and whether the program can achieve its aims with this funding.***

Older Adult Peer Support Program also lacks details to adequately evaluate. The CSS Committee is concerned about the numbers of paid personnel, and *services are likewise short on funding.*

How is the Older Adult service program staffed? Of particular concern is the disconnect between the county's report about the degree of unmet need among older adults and the response to be provided by this program.

A Wellness Recovery and Support Center is planned, as well as development of two part-time consumer drop-in centers in Guerneville and Petaluma. The latter effort is intended to address the problem of minimal access to services for consumers in rural and outlying areas. The plan states that the program will serve transition age young adults, adults, and older adults, as well are persons of all genders, sexual orientation, races and ethnicities. The centers will be challenged to serve a widely diverse community, and the aim is to serve a cumulative total of 300 consumers during three-year funding period.

The program seems to be generously funded, and many consumer positions are planned. The focus is on social rehabilitation skills, and also includes substance abuse counseling services. *Are mental health services adequate in this plan intended to fill service gaps in areas where access is impeded by distance, lack of transportation, as well as shortage of primary medical care services? Sonoma County states that the implementation plan will be developed in consultation with the MHSA Consumer Group and Mental Health Board.* ***The CSS Committee will want to review the progress and success of this program, which could provide valuable services under the right circumstances.***

Overall, the Committee remains concerned about a lack of investment in and emphasis on Wellness, Recovery, Resilience models of service.

CONCLUSION

The overarching question for the Oversight and Accountability Commission is: "How will the three-year CSS plan move your county system forward to meet the standard of comprehensive, timely, appropriate services in the Mental Health Services Act**?"** **The Commission asks that the county prepare to answer this question as the first year of CSS plans are implemented.**

The Commission recognizes the need to build a more reliable baseline of information available to everyone, so that answers can be understood within a context. To do so, the Commission is seeking to develop a description of the mental health system in your county, and in all counties, including an explanation of the structure of the service delivery system, access policies for all children and adults, and range of services received by those not in a categorical funded program.

The Commission is working to develop a baseline to assess the gaps between existing standards of care in mental health and the comprehensive, integrated services envisioned by the Mental Health Services Act. Statewide and national reports tell us that services have been limited and effectively rationed because funding is not tied to caseloads. The Commission believes it will be advantageous to all of the individuals and the private and public organizations involved in change, and beneficial to the public, to have a realistic understanding of the challenges to transforming the mental health system.

In the coming year, the Commission will seek information such as the average caseloads for personal service coordinators and/or case managers and for psychiatrists for the largest percentage of people served. We would like to know what percentage of all mental health consumers are receiving or have access to comprehensive, appropriate, and integrated services, such as individual or group therapy, family counseling, routine medical and dental care, educational or vocational training, substance abuse treatment, supportive housing, and other recovery-oriented services.

To begin with, the Commission will compile available data from traditional sources, and utilize the information you have provided in the CSS plan. In this first year of implementation, we will be enlisting your assistance in measuring the magnitude of changes taking place now and the prospective changes for many years to come. The Commission also will be asking you to determine and report on what resources are lacking in your county. The CSS Committee recognizes the tremendous effort involved in the planning process and commends the county on its many successes.